Mississauga Halton **LHIN**

Better Health Care Experience – Better Health Care Outcome

2009-2010 Annual Report

Ontario
Local Health Integration Network

The MH LHIN and its healthcare partners are picking up the pace!

A Message from the Chair and CEO

"Health Care Governance in Volatile Economic Times; Don't Waste a Crisis"

(Ontario Hospital Association)

The quote referenced above is one that has directed and continues to epitomize the Mississauga Halton LHIN's strategy and decision making. As all of the LHINs move forward towards a refresh of their respective Integrated Health Service Plans for 2010-2013, they must not only continue to leverage existing structures and programs, but also look forward towards innovative and creative solutions to the existing crisis in our system.

2009-2010 has been a year of transformation for the MH LHIN, not so much a transformation from our original goals as highlighted in our Mission, Vision and Values statements, but more so in our emphasis on System Integration. The LHIN has made great strides towards ensuring the 'right care in the right place at the right time' for its residents. Reducing the time wasted in waiting for that 'right care' has been one of the provinces key priorities for Health System Change. A challenge to be sure, but a challenge the MH LHIN has accepted as vital if we are to improve the quality of health care, in terms of the focus on care in the right place. Province wide, "40,000 patients were admitted to hospitals last year for ambulatory care sensitive conditions that could have been better managed in the community."

Working with our community partners the MH LHIN has initiated programs and allocated funding in support of programs designed to promote appropriate assessment and quality care within a community setting. Nurse Practitioners in our Long-Term Care Homes have reduced unnecessary transfers of Long-Term Care Home residents. Aging at Home programs and enhanced homecare, keeping our residents safe and appropriately cared for in their own homes, have also contributed to a reduction in Emergency Department visits and hospital admissions.

If we are to be guided by the quote from the OHA, we must continue to view this crisis in health care as the stimulus for finding creative solutions through collaboration with our health care partners. Our focus must move from its reliance on hospital in-patient care and continue to seek and initiate programs which will provide appropriately assessed, high quality and safe, care within our LHIN communities.

Over the past year we allocated $1,145,448,392 in provincial funding to our local health service providers. Our LHIN community was actively engaged in helping to shape our future direction through a series of Health Service Provider Engagement Sessions. Board Governance to Governance Sessions held throughout the year helped to build and strengthen relationships and share aspirations for a better health system.

Another approach to 'Right Care in the Right Place' is to further develop the concept of "Centres of Excellence" within the Acute Care System. To this end, this past year has seen the MH LHIN move one of its key strategic committees, the Acute Care Capacity Steering Committee, to a Clinical Integration Programs Oversight Committee (CIPOC). Working with its acute care partners, CIPOC will take a leadership role through sustained engagement of regional stakeholders and make recommendations to the LHIN Board for funding allocations to ensure the continued success of acute care regional programs.

The crisis in health care can be viewed as an opportunity to do things you've never done before - an opportunity, not to be wasted. Appropriate care at the right time and in the right place will not only improve the quality of care and of life, but will do so with less waste, on all levels. Health care reform that was once a long term goal is now one that is immediate. We must do it now!

The residents of Ontario deserve it and the Mississauga Halton LHIN will strive to make it happen.

John Magill, Board Chair

Bill MacLeod, CEO

Introduction

2009-10 was a year of significant accomplishment for the Mississauga Halton LHIN. It was a year in which we were able to sharpen our focus on helping our providers deliver a better health care experience with better health care outcomes for residents of our LHIN. That focus is reflected in the title of this report.

This past year was characterized by an ongoing commitment to community engagement. The Mississauga Halton LHIN works with, monitors and funds 77 Health Service Providers (HSPs) that deliver services to more than one million people throughout our region. It is a responsibility in which we take great pride. We never forget that the people best able to set priorities for health care in any community are the people who deliver, and the people who receive, that care. Our responsibility, always, is to listen to them.

The Mission, Vision and Values you see below are more than just words at the beginning of an annual report. They inform what we do, every day.

Our Mission

To lead health system integration for our communities

Our Vision

A seamless health system for our communities - promoting optimal health and delivering high quality care when and where needed.

Our Values

Innovation:	We explore and support imaginative initiatives and solutions
Integrity:	Our actions and words reflect honesty, integrity and good judgment
Accountability:	We will routinely evaluate our judgments and decisions
Partnership:	We will work in partnership with our community, health service providers and the provincial government
Respect:	We will actively listen and work together with dignity and consideration
Holistic Approach:	Our work will reflect and recognize the connection between the body, mind and spirit

LHIN Profile

The Mississauga Halton LHIN has a skilled and committed community of health care providers delivering care to our residents in a variety of health care organizations. These include three hospital corporations with six sites, 34 community support services, 27 long-term care homes, 12 mental health and addictions services and one community care access centre. Our work with all of them is characterized by an unswerving commitment to a better, more integrated health care system.

Our LHIN is one of the geographically smallest in the province, but it is the sixth largest in terms of population. We serve the communities of Mississauga, Oakville, Milton, Halton Hills and South Etobicoke, and are home to 1,131,524 residents – 8.66 percent of Ontario's population. We are growing fast. Our population has grown approximately 20 percent since 2001, and it is expected that [over the next five years] between 2009 and 2014, we will experience further growth of 10.4 percent, which translates into approximately 118,000 more residents.

Ours is a diverse community. We have a higher proportion of immigrants and visible minorities than the province as a whole. The predominant visible minority is South Asian, though there are significant Chinese, Black and Filipino populations as well. In 2006, approximately 41 percent of our residents listed, as their mother tongue, a language that was neither English nor French, which is significantly higher than the provincial average of 27 percent. The non-official language spoken most often in the Mississauga Halton LHIN is Polish.

Relative to the rest of Ontario, the Mississauga Halton LHIN has a small francophone population. Our LHIN is home to 15,600 people – 1.7 percent of the population – whose mother tongue is French. More than half of the francophones in the MH LHIN live in the City of Mississauga.

There are no First Nations reserves in the Mississauga Halton LHIN. Aboriginal people make up a very small portion (0.4 percent) of the total population. There are 4,400 aboriginals living in the MH LHIN.

Our LHIN's diversity both enriches and strengthens our neighbourhoods, but it also contributes to variations in health status which must be considered in any and all health care planning. The health status and care needs of our residents differ across our LHIN. This is not an unusual circumstance for any LHIN. We know, for instance, that people with low incomes are more likely to report poor or only fair health. The Mississauga Halton LHIN has fewer low-income families than the provincial average, but the residents with lower incomes that do live here are more likely to suffer from chronic diseases, such as diabetes and arthritis, than those with higher incomes. We know also that some immigrants and visible minorities, many aboriginal people, single-parent families and people with disabilities tend to be found in the lower income bracket. As a result, they all have distinct health care profiles and require tailored health care responses.

Integrated Health Service Plan

The first major initiative for all Local Health Integration Networks was the creation in 2007 of Integrated Health Service Plans (IHSPs) – three year strategic plans that map out priorities and action plans for creating accessible, coordinated and integrated local health systems, consistent with provincial strategic directions.

At the Mississauga Halton LHIN, we developed our IHSP through extensive consultation with our community, local health service providers and key health partners. For the past three years it has guided and informed our activities, and helped us lay the foundation for future planning initiatives.

As noted above, IHSPs are three year plans, which means that one of our most significant activities this past year was the creation of a plan to take us through the *next* three years. The Mississauga Halton LHIN's Integrated Health Service Plan 2010-2013 was released in late 2009. It was based on extensive consultation with our community. The IHSP not only describes our vision for health care in our communities, but also highlights the means by which we plan to pursue that vision in the years to come.

✓A Year of Accomplishments ✓

2009-10 was a year in which the Mississauga Halton LHIN was able to move forward on a number of fronts, as we continued to lead health service integration in our communities while supporting the provincial government's overall goals for health care.

✓ *Improved Emergency Department Wait Times*

The Ontario government has made reducing the amount of time that patients wait in emergency rooms one of its top health care priorities, and the Mississauga Halton LHIN shares that priority. One of the province's key strategies for reducing wait times is the Pay-for-Results program, under which hospitals are given incentives to meet specific targets and reduce the time patients spend in the Emergency Department (ED).

Our three hospitals all utilized Pay-for-Results strategies. These included:

- Expansion of bed capacity;
- Creation of a Rapid Assessment & Fast Track (RAFT) unit to more quickly respond to patient needs; and
- Adding a dedicated Patient Care Manager to focus on the flow and monitoring of patients in the ED.

✓*Hospital Emergency Department Performance Improvement*

Improvement has been achieved in the Mississauga Halton LHIN hospitals' Emergency Department performance in 2009-2010 through intense engagement of hospital emergency physicians, hospital management and community partners.

Improvement strategies to increase the flow of patients through the hospital and emergency departments, and increased ED avoidance has been achieved through targeted Emergency and Aging at Home investments.

The performance results are highlighted in the chart below.

✓ ***Mississauga Halton LHIN Hospital Emergency Department Performance Improvement***
Length of Stay (LOS) Targets

Indicator 1. % of Admitted patients treated within the LOS target of ≤ 8 hours			
Site Name	**Baseline**	**Target**	**Actual**
Credit Valley Hospital, The	23.1%	33.1%	**32.0%**
Halton Health Services - Georgetown	52.0%	62.4%	**84.5%**
Halton Health Services - Oakville	47.0%	56.7%	**57.4%**
Trillium Health Centre - Mississauga	24.0%	34.1%	**28.7%**
Mississauga Halton Target	**30.0%**	**40.8%**	**39.4%**

Indicator 2. % of Non-admitted high acuity patients treated within the LOS targets: CTAS I-II ≤ 8 hrs; CTAS III ≤ 6 hrs			
Site Name	**Baseline**	**Target**	**Actual**
Credit Valley Hospital, The	78.3%	88.3%	**90.1%**
Halton Health Services - Georgetown	94.4%	100.0%	**96.1%**
Halton Health Services - Oakville	87.0%	97.0%	**92.8%**
Trillium Health Centre - Mississauga	67.8%	77.8%	**73.7%**
Mississauga Halton Target	**80.0%**	**89.6%**	**86.7%**

Indicator 3. % of Non-admitted low acuity patients treated within the LOS target of ≤ 4 hours			
Site Name	**Baseline**	**Target**	**Actual**
Credit Valley Hospital, The	90.8%	100.0%	**93.8%**
Halton Health Services - Georgetown	88.3%	98.3%	**92.1%**
Halton Health Services - Oakville	81.8%	91.8%	**90.4%**
Trillium Health Centre - Mississauga	82.9%	92.9%	**82.7%**
Mississauga Halton Target	**86.0%**	**93.9%**	**89.4%**

✓*Emergency Department (ED) Awareness*

Working collaboratively with our hospitals and the MH Community Care Access Centre (CCAC), the Mississauga Halton LHIN has developed a program that assists our Emergency Department patients feel better faster.

The ED Awareness Campaign, ***Feel Better Faster,*** was rolled out towards the end of fiscal year 2009-10 and was designed to provide information, to those patients who may not require the level of acuity provided by an acute care facility, regarding other options for care within their community.

Last year, one-third of the nearly 306,000 visits made to emergency departments within the Mississauga Halton LHIN were patients with injuries or illnesses who might have been treated elsewhere. The MH LHIN sponsored and engaged with our hospitals and the CCAC to inform the people in our community about how and where to find the help they need.

Posters, brochures and information sheets were created and distributed to all our Health Services Providers, MPPs and to the media. It is hoped that our upcoming fiscal year will report significant improvement in Emergency Department Wait Times due to programs such as ***Feel Better Faster***.

✓*Improved Patient Management in Hospitals*

When a patient is occupying a bed in a hospital, but does not require the intensity of care hospitals were designed to provide, he or she is designated as an Alternate Level of Care (ALC) patient. ALC refers to the level of care that could be made available in the community with the appropriate support systems in place. The time that these ALC patients, often seniors, who remain in hospital waiting for the appropriate alternative environment is measured in 'ALC Days'

In 2009-10, as part of an overall provincial ALC strategy, our LHIN made reducing the number of ALC days a key priority. Significant progress has been made. The MH LHIN, conceptually, referenced ALC as *Appropriate* Level of Care, and our specific goals were to reduce the length of stay in hospitals for ALC patients, reduce the demand for long-term care homes, and reduce unnecessary visits to the ED, by increasing the availability of support programs in the community

In 2009-10, as a result of these investments, we were able to reduce ALC days by 30%

Our investments were directed to

- improving community-based care for seniors with complex needs;
- improving the capacity of long-term care homes to care for higher needs seniors; and
- improving assessment tools across our LHIN health care sector to ensure that people were receiving the **right care, in the right place, at the right time.**

✓ *Increased Supports for Seniors and Caregivers*

We believe that better care for seniors involves helping them live safely and with dignity, whether in their own home, with enhanced homecare support or in an alternative setting appropriate for their needs.

We take great pride in the quality of the programs the MH LHIN has initiated to help seniors in their communities, but we realize that there are many more opportunities to improve access and enhance the coordination of our services, and to make the system more user-friendly for our senior population. The Mississauga Halton LHIN is committed to exploring those opportunities.

In August 2007, the Ontario government announced a new Aging at Home initiative, under which community living options for seniors are expanded dramatically, with a wider range of home care and community support services available to enable people to continue leading healthy and independent lives in their own homes.

Implementation of the Aging at Home strategy is being led by the Local Health Integration Networks. As a result of this strategy, the Mississauga Halton LHIN has identified and funded a number of initiatives designed to allow our seniors to live healthy, independent lives in their own homes, receiving the right care, at the right time, in the right place.

In 2009-10, the MH LHIN invested $18.9 million in initiatives that support the Aging at Home Strategy, an increase of $11.2 Million from the previous year.

These initiatives not only enhance our seniors' experiences with the health care system, they improve patient safety and increase overall efficiency throughout the system. Some of the more notable initiatives include:

Recharge Respite Program

The Recharge Respite Program is an in-home respite service that provides up to 168 hours of temporary caregiver relief. These services include one-to-one supervision, bathing, feeding, personal assistance, as well as other companionship activities.

Supports for Daily Living

The Supports for Daily Living (SDL) program was launched in 2008-09 in the Mississauga Halton LHIN and was an immediate success. So much so that we expanded it this past year. The program is designed to provide frail seniors with the help and support they need to continue living at home. The services, delivered by trained staff, range from personal support to homemaking, safety and reassurance checks as well as 24-hour urgent response.

Enhanced Homecare

Under the umbrella, *Enhanced Homecare*, homecare programs were built upon by expanding the *Stay at Home* and *Wait at Home Programs*. The **Stay at Home** program enables seniors to be discharged from hospital to their own homes with enhanced homecare in place while they regain their strength and ability to care for themselves. **Wait at Home** enables those patients who will require a higher level of care environment, i.e. supportive housing or Long-Term Care Home, to wait safely at home with this enhanced homecare in place.

The MH LHIN invested a substantial amount of funds to provide enhanced homecare services for our seniors with high needs in order to enable them to stay at home.

Geriatric Intensive Care Management Program

Similarly, the new Geriatric Intensive Case Management Program is designed to help ease the load on Emergency Departments by helping seniors find better and more appropriate care outside the hospital. When patients aged 75 or older who have been to an ED are back at home, they are contacted by a case manager to determine if and how their health needs, going forward, might be better met in a community setting.

Nurse Practitioners in Long-Term Care Homes

Over 4,000 of our most frail elderly live in Long-term Care homes (LTC Homes). Many of these residents have frequent visits to emergency departments. In order to increase nursing and help physicians serving in LTC homes, the MH LHIN has invested close to $450,000 to expand the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) program. This is an extremely important program that has helped a great many seniors in our LHIN's LTC Homes, avoid unnecessary trips to hospital – reducing strain on both them and the overall health care system.

NPSTAT is an innovative nurse outreach program funded by the LHIN and managed by The Credit Valley Hospital.

This team of nurse practitioners travel to LTC Homes where, working with physicians and nursing staff in the Home, they assess urgent problems, determine the need for hospital care, and provide interventions such as intravenous therapy, antibiotic management and administering oxygen. These interventions frequently avoid unnecessary transfers to hospital, and in cases where hospitalization is required, NPSTAT facilitates earlier discharges.

More seniors receiving care at home

As a result of these various investments in better care for our seniors, we were able in 2009-10 to reduce the number of LTC placements in our LHIN by 296, and shorten the demand wait list for those placements by more than 13 percent.

✓ *Preventing & Managing Chronic Disease*

Good management of a chronic disease can help prevent the onset of multiple complications as people age. This is important for individuals and also for the health system. As our population ages, there will be more people with chronic conditions such as diabetes, asthma, heart disease, arthritis and high blood pressure. This will place significant pressure on local health system resources. We can also expect increased visits to family doctors and the EDs. Patients with multiple chronic conditions tend to have longer hospital stays, higher health care costs, increased mortality and higher hospital readmission rates.

Improved Access to Diabetes Care

The Government of Ontario has made the treatment of chronic disease, in particular diabetes, one of its top priorities, as have we in the Mississauga Halton LHIN. The prevalence and incidence of diabetes is increasing in our LHIN. Between 2004 and 2006, the number of people suffering from instances of diabetes increased from 60,604 to 70,749 – an increase of 14.3%. Our goal, consistent with the provincial strategy, is to improve the quality of care available to these patients and ensure that more of them have proper access to that care.

In 2009-10, we identified Halton Healthcare Services as the host organization for a Regional Coordination Centre for Diabetes. This Centre will leverage local resources and existing expertise to ensure the integration of diabetes services across the continuum of care, so that individuals living with, or at risk of developing, diabetes have the access to the services they need.

Insulin Starter Kits

Insulin is a critical treatment for many diabetics, but many first time users face barriers when taking the hormone for the first time. These barriers can range from emotional – a fear of needles – to educational – simply not knowing how to self-administer. An innovative new kit developed this past year by diabetes experts in our LHIN contains tools health care professionals can use in helping new insulin users address these issues.

Improving Quality of Care for Diabetes Patients in LTC Homes

To ensure that residents with diabetes in Long-Term Care Homes receive high quality care based on the best available evidence, physicians, nurses and administrators were provided with enhanced education and information on the management of diabetes for the senior population.

Diabetes Mobile Outreach Team

Self-care is a critical component of diabetes management, and people with diabetes are encouraged to take an active role in the day-to-day management of their disease. This self-care, however, requires certain skills. Three new diabetes education teams, consisting of a nurse and a dietician, were introduced across the LHIN in 2009-10, and one of these teams was designated to be a Diabetes Mobile Outreach Team.

Most diabetes patients receive their care through family physicians, and the goal of the mobile outreach team is to provide education about self-care to patients within the family physicians' offices.

Improved Access to Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program is a workshop for people with different chronic disease, not just diabetes. The workshop teaches the skills needed in the day-to-day management of treatment. 176 people registered for the 15 programs that were held over the past year. In addition, the LHIN held four Stanford Training education sessions across the LHIN and trained 41 new leaders in the Stanford Model of self-management. These leaders will serve as "champions" of self-management across our different health care organizations.

✓ *Mental Health and Addiction*

This past year, we continued moving towards the delivery of a coordinated and accessible range of services to citizens in our community suffering from mental health and addictions illnesses.

Towards the end of fiscal year 2009-10, the MH LHIN, in collaboration with the Canadian Mental Health Association – Halton Region and our Community Mental Health and Addictions partners in the diagnosis and treatment of mental health and addictions, brought forward an initiative designed to reduce 'repeat visits' to hospital Emergency Departments by those suffering from a concurrent disorder. It is estimated that approximately 50% of people diagnosed with a mental disorder also have a substance abuse problem. These are the clients with concurrent disorders.

At the end of March 2010, the MH LHIN initiated the **Community Concurrent Disorders Program.** This program enhances and supports the community services for mental health and addictions. It is hoped that this initiative, which will provide complete, seamless and timely support for these clients, will help reduce the number of visits and repeat visits to our EDs and thus have an impact on ED Wait Times.

Community Engagement

The transformation of Ontario's health care system that began seven years ago has been characterized by a commitment to community-based health care. That commitment led to the creation of LHINs, which were seen as the best vehicle to improve the management of health care at a local level, and to reflect the needs and priorities of the province's many different communities.

A core function of LHINs, therefore, is to engage with those communities in order to establish their needs and priorities, and to

develop appropriate, effective solutions and responses to any problems and concerns that might be raised. LHINs are the only public agency in Ontario with a specific mandate to engage citizens in its decision-making processes.

At the Mississauga Halton LHIN, community engagement has been part of our culture from the very beginning. We understand that we can not do our jobs without the feedback we receive from the people and organizations that we are in the business of helping.

Integrated Health Service Plan

One of the most critical community engagement pieces that we must undertake as a LHIN is regarding the three-year Integrated Health Service Plan. This plan effectively takes the overall map for health care set by the provincial government and fills it in at the local level, reflecting the priorities and concerns coming out of our communities. Because community engagement is an ongoing part of our lives as a LHIN, it would be fair to say that we are always preparing a health service plan. Every three years, however, that preparation takes on a sharper focus. Accordingly, in 2009 we undertook an extensive period of community engagement as we developed the Mississauga Halton IHSP 2010-2013.

Before beginning the actual engagement, we developed focus areas in order to frame our discussions. These were:

- Improving access, quality and sustainability of the health system;
- Enhancing seniors' health, wellness and quality of life;
- Integrating mental health and addictions services; and
- Prevention and management of chronic conditions.

Over the course of more than two months in Spring 2009, we consulted with a variety of citizens, community leaders and health care stakeholders. Those consultations took the form of focused stakeholder meetings with attendance ranging from just a few experts to hundreds of people. We also conducted a survey online and received more than 400 responses from the survey.

Our engagement process culminated in a Citizens' Reference Panel, a new and innovative way of gathering input from our community. 5,000 invitations were mailed to random addresses, within the MH LHIN community, inviting the bearer to participate in a draw that would decide the membership of the panel. 200 people accepted the invitation to participate in the panel member selection draw. From those, 36 citizens were selected to participate in two intensive days of education and discussion.

Following the Panel, participants submitted recommendations in each of our focus areas. To say that the input we received from our Citizens' Reference Panel was important in the creation of our IHSP would be an understatement.

Over 800 Citizens from our LHIN community were engaged in providing advice on future health system priorities

Aboriginal Initiatives

As part of our IHSP consultation, we engaged specifically with members of our aboriginal community.

On Saturday, June 6, 2009, an event entitled "A Gathering – Peel's Aboriginal Celebration" was held at Chinguacousy Park. Our LHIN hosted a shared booth with the Central West LHIN. It is estimated that over 900 people attended this event featuring Aboriginal entertainment and Elder teachings, and we were very pleased with the opportunity to engage with members of this valued community.

In September 2009, we held a meeting with the Chair of the Peel Aboriginal Network and the President of the Credit River Métis Council. The Aboriginal lead from the Central West LHIN also attended. It was an informational session during which upcoming health events and possible future opportunities for community engagement were discussed.

Francophone Initiatives

One of the many consultations that took place in advance of the IHSP was with members of our francophone community. We know that there is limited information about the specific health needs of francophones in our LHIN, and because they are such a small percentage of our overall population it can be challenging to identify those needs.

We know that in general, francophones have the same concerns about access, quality and sustainability in the health system as do other residents of our LHIN, but we are also aware that these issues are complicated by a lack of health services available in French. While the consultation session was framed by the same priority areas as all our other sessions, the discussions frequently touched on the issue of making it easier for francophones – particularly who are unilingual – to interact with the health system.

Performance Indicators

The Ministry/LHIN Accountability Agreement (MLAA) sets out the obligations of the Ministry of Health and Long-Term Care (MOHLTC) and the MH LHIN to fulfill its mandate to plan, integrate and fund local health care services

Performance management is a key component to a changing health care system and a focus on performance improvement opportunities will guide system partners in aligning local health care needs to health system goals.

The MH LHIN has been successful in maintaining and improving on eight of the eleven provincial performance targets, as well as the LHIN specific targets. Work continues to improve the wait times for cancer surgery and improve timely access to the MRI diagnostic services. Through the LHIN's Aging at Home investments to enhance community support services for seniors and reduce the need to rely on LTC placement, we expect to see the median wait time for Long Term Care placement to decrease over time.

MISSISSAUGA HALTON LHIN MLAA Performance Indicators
FY 2009/2010 - May 14, 2010

PI #.	Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point 2009/10	LHIN Performance Target - 2009 /10	Used Performance Value - FY 2009/10	LHIN Met Target - Within Corridor (YES/NO)
1	90th Percentile Wait Times for Cancer Surgery 1.1	Access	84	51	50	60	NO
2	90th Percentile Wait Times for Cataract Surgery 1.1	Access	182	98	95	96	YES
3	90th Percentile Wait Times for Hip Replacement 1.1	Access	182	183	172	148	YES
4	90th Percentile Wait Times for Knee Replacement 1.1	Access	182	209	182	139	YES
5	90th Percentile Wait Times for Diagnostic MRI Scan 1.1	Access	28	102	95	134	NO
6	90th Percentile Wait Times for Diagnostic CT Scan 1.1	Access	28	37	35	34	YES
7	Median Wait Time to Long-Term Care Home Placement -All Placements 2.1	Integration	50	96	84	129.00	NO
8	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution 2.2	Integration	9.46%	12.78%	8.80%	8.80%	YES
9	Proportion of Admitted patients treated within the LOS target of ≤ 8 hours1.1	Access	90.00%	31.00%	41.00%	39.61%	YES
10	Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III 1.1	Access	90.00%	82.00%	90.00%	87.53%	YES
11	Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours 1.1	Access	90.00%	88.00%	94.00%	89.54%	YES

Notes

Target Assessment

YES = LHIN Met Target / Within Corridor

NO = LHIN Did Not Meet Target / Above Corridor

LHIN Operational Performance

The Mississauga Halton LHIN allocated $1,145,448,392 to its Health Service Providers over this past year, making significant investments in Aging at Home, emergency wait time and appropriate level of care initiatives. We continue to be actively engaged in the funding and performance management of 77 Health Service Providers.

Whenever possible, we also work to actively engage our community in activities that lead to informed decision making with regard to the funding of programs and services with our LHIN.

The MH LHIN's total Operating budget was $5,410,145, of which $4.44 million was for LHIN Operations; $967,000 for projects including eHealth, French Language Services, ED/ALC and others.

Our work is managed by a dedicated to Performance Improvement and Integration, Health System Development, Finance & Risk Management and Information & Project Management.

Throughout the year, we maintained a lean but energetic team of 30 employees who actively facilitated collaboration amongst Health Services Providers to help move the MH LHIN's initiatives forward.

Our work continues to be supported by the extended efforts of volunteer teams consisting of representatives from funded Health Service Providers. Throughout the year we make every effort to support our staff in leading health system change initiatives and are proud to promote a learning environment that focuses on continuous learning and professional development.

Mississauga Halton LHIN Directory

Our Staff:

Judy Bowyer	Sr. Lead Performance Improvement & Integration
Bill Campbell	Director, Health System Development
Kim Delahunt	Manager, Communications and Community Engagement
Nancy Dembinski	Administrative Assistant
Dwain Dolland	Special Projects Coordinator
Maria Fernandes	Program Assistant
Margaret Finnigan	Administrative Assistant
Charity Gaspar	Executive Assistant
Andrew Hussain	Chief Information Officer
Angela Jacobs	Sr. Lead Performance Improvement & Integration
Greg Kaplan	eHealth Project Manager
Roberta Lee	Sr. Lead Performance Improvement & Integration
Rob Low	Sr. Lead Health System Development
Bill MacLeod	Chief Executive Officer
Marco Marchitto	Planning Analyst
Shelley Martin	Corporate Services Assistant
Joe Mauti	Sr. Lead Health System Development
Bill Ng	Sr. Information Lead
Monita O'Connor	Director Performance Improvement & Integration
Priti Patel	Sr. Lead Health System Development
Raj Rehill	eHealth Program Manager
Mirella Semple	Financial Analyst
Narendra Shah	Chief Operating Officer
Dominic Sloan	Manager, Corporate Services
Susan Swartzack	Sr. Lead Health System Development
Sue Turcotte	Director Finance & Risk Management
Henry Van Boxtel	PMO Lead
Kitty Varley	Lead Communications & Community Engagement
Heather Willis	Sr. Lead Performance Improvement & Integration
Paulette Zulianello	Sr. Lead Funding and Allocations

Health Service Providers Funded by the Mississauga Halton LHIN

Sector	Name of Health Service Provider
Community Support Services	Acclaim Health and Community Care Services Alzheimer Society of Peel BALANCE - Blind Adults Learning About Normal Community Environment Canadian Hearing Society (The) Canadian National Institute for the Blind - CNIB - Ontario Division (Halton/Peel) Canadian Red Cross - Peel Branch City of Mississauga - Next Step to Active Living Program Corporation of the Town of Halton Hills (The) Dixie Bloor Neighborhood Drop-In Centre Dorothy Ley Hospice Inc. Forum Italia Community Services - MICBA Halton Health Care Corporation - Supportive Housing Hospice of Peel Inc. India Rainbow Community Services of Peel Islington Centre - Etobicoke Senior Citizens Ivan Franko Home Joyce Scott Non-Profit Homes Inc. Links2Care Milton Meals on Wheels Nucleus Independent Housing Oakville Kiwanis Meals on Wheels Oakville Senior Citizens Residence Ontario March of Dimes - Peel Peel Cheshire Homes Inc. (Streetsville) Peel Halton Acquired Brain Injury Services Peel Senior Link Regional Municipality of Halton - Supportive Housing S.E.N.A.C.A. Seniors Day Program Seniors Life Enhancement Centres Trillium Health Centre – CSS Victorian Order of Nurses - Peel Branch Wawel Villa Incorporated Wesburn Manor - Toronto Long-Term Care Homes and Services Yee Hong Centre for Geriatric Care

Sector	Name of Health Service Provider
Long Term Care Homes	Allendale - The Regional Municipality of Halton
	Bennett Health Care Centre
	Cawthra Gardens Long Term Care Community
	Dom Lipa Nursing Home (Slovenian Linden Foundation)
	Erin Mills Lodge Nursing Home (Devonshire Erin Mills Inc.)
	Extendicare - Halton Hills
	Extendicare - Mississauga
	Highbourne Lifecare Centre - The Royal Crest Lifecare Group Inc.
	Labdara Lithuanian Nursing Home
	Leisureworld Caregiving Centre - Mississauga
	Leisureworld Caregiving Centre - Streetsville
	Mississauga Lifecare Centre - The Royal Crest Lifecare Group Inc.
	Mississauga Long Term Care Facility
	Northridge Long Term Care Facility
	Post Inn Village - The Regional Municipality of Halton
	Sheridan Villa (Regional Municipality of Peel)
	Specialty Care Mississauga Road
	Tyndall Nursing Home
	Villa Forum Nursing Home - MICBA
	Village of Erin Meadows - Oakwood Retirement
	Waterford (The) Regency Care
	Wenleigh (The)
	Wesburn Manor - Toronto Long-Term Care Homes and Services
	West Oak Village Long Term Care Facility
	Westbury (The)
	Wyndham Manor - Halton Health Care LTC Inc.
	Yee Hong Centre for Geriatric Care

Sector	Name of Health Service Provider
Mental Health & Addictions	Canadian Mental Health Association - Halton Branch Credit Valley - Community Mental Health Grace House Group Home Halton Alcohol, Drug & Gambling Assessment Prevention and Treatment (ADAPT) Halton Health Care Services Corporation - Community Mental Health Halton Recovery House & Hope Place Women's Treatment Centre North Halton Mental Health Clinic Summit House Support & Housing - Halton Supported Training and Rehabilitation in Diverse Environments (STRIDE) The Peel Addiction Assessment and Referral Centre Trillium Health Centre - Community Mental Health
Hospitals	Credit Valley Hospital Halton Healthcare Services Corporation Trillium Health Centre - Mississauga
Community Care Access Centre	**Mississauga Halton Community Care Access Centre**

THE MH LHIN Board

Board of Directors

The role of the Mississauga Halton LHIN's Board Directors is to provide independent and objective oversight to the planning, funding, and performance management of health care within the Mississauga Halton LHIN. As a member of a diverse team, Board members are responsible for providing oversight in setting the goals, objectives, and strategic directions for the LHIN within its mandate as defined by the LHIN's Legislation and Regulations plus its approved Memorandum of Understanding and Ministry/LHIN Accountability Agreement. Collectively, members of the Board oversee the direction and performance of the LHIN and as individuals are accountable to the Board as a whole and to the Minister of Health and Long-Term Care

The Mississauga Halton LHIN Board

Board Member	First appointed	Current Term
John Magill, Board	June 1, 2005	June 9, 2008 to June 8, 2011
Norman Murray, Vice Chair	January 5, 2006	January 5, 2008 to January 4, 2011
Enola Stoyle, Secretary	June 1, 2006	June 9, 2008 to June 8, 2010
Brij Chadda, Member	May 17, 2006	June 17, 2007 to June 16, 2010
Caesar Cheng, Member	January 5, 2006	January 5, 2008 to January 4, 2011
Tim Costigan, Member	May 17, 2006	June 17, 2007 to June 16, 2010
Elliot Halparin, MD, Member	June 1, 2005	June 9, 2008 to *February 4, 2010*
Edward R. Morris, Member	January 5, 2006	February 5, 2007 to *February 4, 2010*
Jane McCarthy, Member	May 17, 2006	May 17, 2008 to May 16, 2011
Jason Wadden, Member	February 5, 2010	February 5, 2010 to February 4, 2012
Renu Minhas, Member	March 24, 2010	March 24, 2010 to June 8, 2011

Financial statements of

Mississauga Halton Local Health Integration Network

March 31, 2010

Mississauga Halton Local Health Integration Network

March 31, 2010

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Deloitte.

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Auditors' Report

To the Members of the Board of Directors of the
Mississauga Halton Local Health Integration Network

We have audited the statement of financial position of the Mississauga Halton Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Mississauga Halton Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 30, 2010

Member of / Membre de Deloitte Touche Tohmatsu

Mississauga Halton Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**816,342**	762,774
Accounts receivable	**11,598**	6,139
Accounts receivable Ministry of Health and Long-Term Care ("MOHLTC") transfer payments to Health Service Providers ("HSPs") (Note 3)	**14,083,200**	11,562,400
Due from MOHLTC (Note 4b)	**35,000**	-
Due from other Local Health Integration Network ("LHIN") - Project Funds	**48,697**	-
Due from the LHIN Shared Services Office (Note 5)	**3,554**	-
	14,998,391	12,331,313
Liabilities		
Accounts payable and accrued liabilities	**689,192**	759,369
Accounts payable HSPs transfer payments (Note 3)	**14,083,200**	11,562,400
Due to MOHLTC (Note 4b)	**228,663**	18,279
Due to the LHIN Shared Services Office (Note 5)	**-**	7,494
Deferred capital contributions (Note 6)	**109,025**	283,777
	15,110,080	12,631,319
Commitments (Note 7)		
Net debt	**(111,689)**	(300,006)
Non-financial assets		
Prepaid expenses	**2,664**	16,229
Capital assets (Note 8)	**109,025**	283,777
	111,689	300,006
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Mississauga Halton Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

	Budget (unaudited) (Note 9)	2010 Actual	2009 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 3)	**1,124,001,599**	**1,145,448,392**	1,090,153,327
Operations of LHIN	**4,184,600**	**4,174,408**	4,018,491
Other funding initiatives (Note 12)	**605,000**	**967,100**	538,300
Amortization of deferred capital contributions (Note 6)	-	**268,637**	260,135
	1,128,791,199	1,150,858,537	1,094,970,253
Expenses			
Transfer payments to HSPs (Note 3)	**1,124,001,599**	**1,145,448,392**	1,090,153,327
General and administrative (Notes 10 and 11)	**4,184,600**	**4,386,320**	4,272,383
Other funding initiatives (Note 12)	**605,000**	**848,441**	526,264
	1,128,186,199	**1,150,683,153**	1,094,951,974
Annual surplus before funding repayable to the MOHLTC	-	**175,384**	18,279
Funding repayable to the MOHLTC (Note 4a)	-	**(175,384)**	(18,279)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Mississauga Halton Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2010

	Budget (unaudited) (Note 9)	2010 Actual	2009 Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	**13,565**	(14,861)
Acquisition of capital assets	-	**(93,885)**	(166,109)
Amortization of capital assets	-	**268,637**	260,135
Decrease in net debt	-	**188,317**	79,165
Opening net debt	-	**(300,006)**	(379,171)
Closing net debt	-	**(111,689)**	(300,006)

Mississauga Halton Local Health Integration Network

Statement of cash flows
year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Add item not affecting cash		
Amortization of capital assets	**268,637**	260,135
Less items not affecting cash		
Amortization of deferred capital contributions (Note 6)	**(268,637)**	(260,135)
	-	-
Changes in non-cash operating items		
(Increase) decrease in accounts receivable	**(5,459)**	1,101
Increase in Due from MOHLTC	**(35,000)**	-
Increase in Due from other LHIN	**(48,697)**	-
Increase in Due from the LHIN Shared Services Office	**(3,554)**	-
Increase in accounts receivable MOHLTC transfer payments to HSPs	**(2,520,800)**	(10,091,890)
(Decrease) increase in accounts payable and accrued liabilities	**(70,177)**	143,616
Increase in accounts payable HSPs transfer payments	**2,520,800**	10,091,890
Increase (decrease) in due to MOHLTC	**210,384**	(338,663)
(Decrease) increase in due to the LHIN Shared Services Office	**(7,494)**	5,650
Decrease (increase) in prepaid expenses	**13,565**	(14,861)
	53,568	(203,157)
Capital transactions		
Acquisition of capital assets	(93,885)	(166,109)
Financing transactions		
Capital contributions received (Note 6)	**93,885**	166,109
Net increase (decrease) in cash	**53,568**	(203,157)
Cash, beginning of year	**762,774**	965,931
Cash, end of year	**816,342**	762,774

Mississauga Halton Local Health Integration Network

Notes to the financial statements

March 31, 2010

1. Description of business

The Mississauga Halton Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Mississauga Halton Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2010.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers a south-west portion of the City of Toronto, the south part of Peel Region and all of Halton Region except for Burlington. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairment in the value of assets.

Cash

Cash includes cash on hand and balances with banks.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the Health Service Providers ("HSPs"). The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end. Due to the inability to quantify by year end, the dollar value of surplus funding provided to certain HSPs, these recoverable amounts are not reflected in these statements but will be recovered in the subsequent year.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Web development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,145,448,392 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2010 as follows:

	2010	2009
	$	$
Operation of hospitals	**788,814,383**	758,587,369
Health Infrastructure Renewal Fund (HIRF)	**1,776,895**	-
Long term care homes	**163,183,965**	156,925,812
Community care access centres	**116,037,922**	108,664,824
Community support services	**21,206,070**	19,347,988
Assisted living services in supportive housing	**21,585,324**	16,081,404
Community mental health	**23,664,737**	22,671,891
Addictions program	**4,143,160**	3,980,945
Acquired brain injury	**5,035,936**	3,893,094
	1,145,448,392	1,090,153,327

For Fiscal 2010, Acquired Brain Injury sector has been disclosed separately from the Community Support Services. The comparative figures have been reclassified to conform to this change.

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As at March 31, 2010, an amount of $14,083,200 (2009 - $11,562,400) was receivable from the MOHLTC and $14,083,200 (2009 - $11,562,400) was payable to the HSPs. These amounts have been reflected as revenue and expenses with the LHIN's financial activities and are included above.

Included in the LHIN's transfer payments to HSPs - operation of hospitals as revenue and expense are funding amounts to the Hospitals for the current period although the final performance of the service will occur in subsequent fiscal year due to the timing of the funding. Hospitals are required to obtain LHIN approval to defer revenue to subsequent fiscal years and the LHIN's management monitors these items closely to ensure ultimate performance is achieved.

New investment decisions targeting various initiatives such as the Aging At Home strategy, reduction in emergency room wait times, etc. are included in the above transfer payments to HSPs.

4. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2010 surplus	2009 surplus
	$	$	$	$
Transfer payments to HSPs	1,145,448,392	1,145,448,392	-	-
LHIN operations	4,443,045	4,386,320	56,725	6,243
E-Health	600,000	597,076	2,924	-
ED Lead / ER/ALC Performance Lead	175,000	160,505	14,495	12,036
Diabetes	25,000	25,000	-	
French Language Health Services	162,100	63,633	98,467	
Aboriginal engagement	5,000	2,227	2,773	-
	1,150,858,537	1,150,683,153	175,384	18,279

b. The amount due to the MOHLTC at March 31 is made up as follows:

	2010	2009
	$	$
Due to MOHLTC, beginning of year	18,279	356,942
Funding repayable to the MOHLTC related to current year activities (Note 4a)	175,384	18,279
Funding repayable to MOHLTC for Diabetes Education	35,000	-
Amount recovered by the MOHLTC during the year	-	(356,942)
Due to MOHLTC, end of year	228,663	18,279

The funding repayable to the MOHLTC for Diabetes Education relates to the Self-Management Capacity Building Initiative under the Ontario Diabetes Strategy. This initiative was not included in the Statement of Financial Activities for the year ended March 31, 2010 due to the timing of the funding announcements.

5. Shared services agreement

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

In fiscal 2010, the Local Health Integration Network Collaborative ("LHINC") became a division of the Toronto Central LHIN. LHINC was formed to foster engagement of the LHINS' HSP community and encourage collaborative integration of the health care system to all LHINs. At the direction of the Steering Committee of LHINC, prior to LHINC assembling their Council, the LHIN approved and paid for expenses on behalf of the LHINC. The total expense incurred was $251,508 (2009 - $128,039) of which $250,434 (2009 – $118,894) was reimbursed by LSSO. LHINC is subject to the same policies, guidelines and directives as the LSSO and Toronto Central LHIN.

5. Shared services agreement (continued)

MH LHIN has also entered into various shared service agreements with respect to the E-health initiative as a shared responsibility to the Central West LHIN, Hospitals and the Mississauga Halton Community Care Access Centre.

6. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**283,777**	377,803
Capital contributions received during the year	**93,885**	166,109
Amortization for the year	**(268,637)**	(260,135)
Balance, end of year	**109,025**	283,777

7. Commitments

The LHIN has commitments under various operating leases related to building and equipment. The current building lease expires December 31, 2010 and therefore commitments for building lease beyond that date is not included below. The LHIN is currently negotiating a lease renewal for its building and it is anticipated the new lease will contain similar terms to the existing lease. Other lease renewals are likely. Minimum lease payments due in each of the next three years are as follows:

	$
2011	179,343
2012	26,774
2013	11,447

The LHIN also has funding commitments to certain HSPs associated with accountability agreements allocating planning targets for fiscal 2010 and 2011. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

8. Capital assets

			2010	2009
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**146,718**	**90,944**	**55,774**	63,226
Computer equipment	**27,479**	**19,667**	**7,812**	10,511
Web development	**77,910**	**32,471**	**45,439**	3,250
Leasehold improvements	**880,162**	**880,162**	**-**	206,790
	1,132,269	**1,023,244**	**109,025**	283,777

9. Budget figures

The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2009 as approved by the LHIN Board. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $1,145,448,392 as at March 31, 2010 is made up of the following:

	$
Initial HSP funding budget	**1,124,001,599**
Adjustments due to announcements made during the year	**21,446,793**
Final HSP funding budget	**1,145,448,392**

The final operating budget excluding HSP funding of $5,235,393 as at March 31, 2010 is made up of the following:

	$
Initial budget	
LHIN operations	**4,184,600**
E-Health	**600,000**
Aboriginal engagement	**5,000**
Additional funding received during the year for:	
Stabilization	**83,693**
ED Lead / ER/ALC Performance Lead	**175,000**
Diabetes	**25,000**
French Language Services	**162,100**
Final budget	**5,235,393**

10. General and administrative expenses

The Statement of Financial Activities presents the expenses by function. The following classifies general and administrative expenses by object:

	2010	2009
	$	$
Salaries and benefits	**2,822,350**	2,632,252
Occupancy	**213,782**	252,513
Amortization	**268,637**	260,135
Shared services	**359,059**	300,000
LHIN Collaborative	**12,286**	-
Integrated Health Service Plan	**96,655**	23,720
Engagement with Stakeholders	**136,378**	143,652
Professional fees	**20,793**	56,820
Supplies	**37,292**	39,577
Board members' per diem expenses (see Note below)	**167,300**	171,175
Board development	**15,619**	54,355
Mail, courier and telecommunications	**54,273**	58,845
Staff travel	**19,382**	24,462
Recruitment	**330**	6,138
Other	**162,184**	248,739
	4,386,320	4,272,383

Included in general and administrative expenses are costs to support the activities of the Board of Directors such as per diems, travel and other general costs. The expenses incurred are as follows:

	2010	2009
	$	$
Board Chair per diem expense	**58,450**	65,975
Other Board member per diem expense	**108,850**	105,200
	167,300	171,175
Other governance costs (reflected in various objects above)	**60,050**	76,181
	227,350	247,356

11. Consulting fees

Within the Salaries and benefits, Integrated Health Service Plan, Engagement with Stakeholders, Recruitment, Professional fees, Board development costs and Other itemized in Note 10, approximately $190,528 (2009 - $180,123) were procured through consultants. The comparative figure has been reclassified to conform with the presentation adopted in the current year, temporary administrative staff are no longer included as consulting.

12. Other funding initiatives

During fiscal 2010, the LHIN received $967,100 (2009 - $538,300) in funding from the MOHLTC and spent $848,441 (2009 - $526,264). These funds were used toward initiatives in support of its strategic E-Health Plan, ED Lead, ER/ALC Performance Lead funding, Diabetes, French Language Health Services and Aboriginal engagement as defined in its Integrated Health Services Plan.

The net unspent amount of $118,659 (2009 - $12,036), of which $98,467 relates to the late funding announcement of the French Language Health Services, is payable to the MOHLTC (Note4a).

13. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 26 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2010 was $224,014 (2009 - $201,268) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan on December 31, 2009. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

CONTACT INFORMATION

Telephone	905-337-7131 1-866-371-5446
Fax	905-337-8330
Address	700 Dorval Dr., Suite 500 Oakville ON L6K 3V3
Email	mississaugahalton@lhins.on.ca
Website	www.mississaugahaltonlhin.on.ca

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Ontario
Local Health Integration Network